Technical Guidance Annex C
Joint Contract Dispute Resolution Process

Contents

1 Introduction

1.1 Scope

NHS England and NHS Improvement have agreed a joint Dispute Resolution Process, the scope of which is detailed below.

This document has been prepared to support the 2017/18-2018/19 contracting round. Where a multi-year contract is in place and the dispute relates to the agreement of the variation to update its terms for 2016/17 then this process will not apply, and the parties must follow the processes set out in their contract to resolve their failure to agree terms for the forthcoming year. Should an in-year contractual dispute arise, the processes set out in the NHS Standard Contract should be used to reach a resolution.

1.2 Expectations

Without signed contracts in place, individual commissioners and providers are unable to plan accurately for the years ahead, while the drawn-out process of negotiation is likely to distract detrimentally from delivery. It is therefore an essential component of the planning process that all commissioners and providers have in place between them, mutually-agreed contracts prior to the start of the 2017/18 financial year; the deadline for this is 23 December 2016.

NHS England and NHS Improvement have very clear expectations for the 2017/18-2018/19 contracting round. All parties must properly engage with one another and ensure that disputes are resolved in time to meet the contract signature deadline of 23 December 2016.

The joint contract tracker submissions are a key part of the contracting process and allow NHS Improvement and NHS England to be clear on the status and progress of contract negotiations, the value of differences as negotiations develop, and likelihood of mediation and arbitration being required to help settle contract disputes. It is essential that all commissioners and providers are engaged in this process and complete the weekly tracker submissions accurately. To help ensure that the contractual relationships are clear and agreed in advance of the joint contract tracker process commencing, a contractual relationship template will be issued for completion by commissioners and validated by providers. Engagement and accuracy from both commissioners and providers is critical and, as noted later in this guidance, failure to properly engage may be taken into consideration in apportioning any fines levied.

Formal arbitration processes are a last resort; organisations should do all they can to avoid disputes and, when they occur, to resolve them swiftly and independently. Resorting to arbitration is a sign that the parties have failed in their duty to work together effectively. Arbitration is a time-consuming process for all parties concerned, and can have a detrimental impact on the working relationships between providers and commissioners.

To reduce the number and scale of these failures, this document also outlines how organisations can be supported in resolving disputes before they require a last resort dispute resolution process.

To assist organisations in understanding the likely outcome of any arbitration cases, NHS England and NHS Improvement have produced a set of contract dispute resolution principles. These principles are included in Appendix 3, and organisations are encouraged to assess their contracting proposals and potential arbitration cases against the principles described.

1.3 Layout of this document

This guidance is divided into four sections:

- **Section *2*** deals with the scope of the dispute resolution process;
- ***Section 3*** describes the different stages of the overall dispute resolution process;
- ***Section 4*** describes the advice and assistance NHS England and NHS Improvement can provide in advance of parties having to enter the final arbitration stage of the dispute resolution process; and
- ***Section 5*** details the last-resort arbitration process for contracting disputes that remain unresolved following contract negotiations. All contracts between commissioners and providers should be signed by 23 December 2016.

2 Operation of the dispute resolution process

2.1 When the dispute resolution process applies

The dispute resolution process applies to disputes arising in relation to agreement of terms for a new contract, as part of the 2017/18-2018/19 planning round:

- between commissioners and providers, and which typically have material financial implications;
- where the scope of the dispute relates to contractual payment, services and obligations; and
- where another means of resolution is not otherwise stated in national guidance.

The advice and mediation stages of the dispute resolution process are advisory for all organisations, and are designed to support the local resolution of disputes without recourse to formal last-resort proceedings. The arbitration stage is mandatory for NHS commissioners and NHS trusts (where contracts remained unsigned after the national deadline date), and is expected to be followed equally by other organisations (see 2.4 for disputes involving Foundation Trusts (FTs) and 2.5 independent providers).

Reflecting on the 2016/17 arbitration process, NHS England and NHS Improvement want to highlight that commissioners and providers should make the most of the mediation stage of dispute resolution, especially when disagreements centre on technical contractual issues. To this end national expertise is available to support the resolution of such issues and utilising this should help parties avoid arbitration. Please see paragraph 4.2 for details of how to access this support.

2.2 Application of the dispute resolution process

This dispute resolution process relates to disputes between providers and commissioners. In this context, 'providers' deliver services and raise invoices; 'commissioners' are organisations that procure services on behalf of their populations. Provider organisations may include Acute Trusts, Ambulance Trusts, Care Trusts, Mental Health Trusts, Community Trusts and independent or third sector providers. Commissioner organisations include Clinical Commissioning Groups (CCGs) and NHS England as a Direct Commissioner.

Providers may hold multiple contracts with different commissioners. For the purposes of this dispute resolution process, where there is a single contract involving multiple commissioners, the dispute resolution process would be applied once to the contract as a whole, not separately for each commissioner party to the contract. The financial thresholds for entering the process will be applied to the aggregate value of each dispute (or grouping of similar disputes) across all commissioners. For the purposes of the dispute resolution process, therefore, the co-ordinating commissioner will represent all of the commissioners who intend to be a party to the contract.

As set out in their collaborative commissioning agreements, co-ordinating commissioners must ensure that they take account of the requirements of other commissioners in negotiating contracts with providers and that issues of importance to these other commissioners are addressed through the mediation and arbitration processes where necessary. In-year disputes should be managed in line with the dispute resolution process set out in the relevant signed contract. Disputes relating to failure to agree a contract for a new financial year should be referred into this dispute resolution process.

Where mediation and/or ongoing negotiation fails, and there is still no signed contract in place by the national deadline for contract signature of 23 December, the parties should expect to enter the arbitration process, and should begin drafting the necessary papers.

Parties that fail to reach agreement by the national deadline will be required to present themselves to the Chief Executives of NHS Improvement and NHS England (or their representatives) to explain the nature of their dispute and why they have been unable to reach agreement.

2.3 Specifics for disputes involving NHS trusts

Commissioners and NHS trusts should work to ensure that contracts are signed no later than the national deadline. Arbitration is mandatory for NHS commissioners and NHS trusts whose contracts remain unsigned by the final date for avoiding arbitration, 23 December 2016.

The parties must jointly submit by 9 January 2017 either:

- a copy of the signature page to evidence agreement, together with a list of any minor, non-material unresolved items which the parties accept can be finalised

after contract signature (section 2.7 describes the key elements of an agreed contract; note that contracts should not be signed with material issues outstanding and that such issues must not be 'parked' as outstanding 'long stop' items); or

- arbitration papers (completed and submitted jointly by the provider and the co-ordinating commissioner).

2.4 Specifics for disputes involving NHS Foundation Trusts

NHS foundation trusts (as public benefit corporations) are independent legal entities. Contracts signed by these organisations are legally binding documents, ultimately enforceable by the courts.

Although arbitration is not mandatory for FTs in a statutory sense, NHS Improvement expects well-governed FTs to take all reasonable steps to achieve signed contracts in a timely manner and consistent with the values of the NHS. Therefore in all cases where FTs fail to achieve signed contracts with their commissioners in accordance with the national timetable, NHS Improvement expects those FTs to voluntarily enter arbitration.

On 9 January 2017, the parties must jointly submit either:

- a copy of the signature page to evidence agreement (see section 2.7 for what constitutes an agreed contract), together with a list of any minor non-material unresolved items which the parties accept can be finalised after contract signature; or

- arbitration papers (completed and submitted jointly by the provider and the co-ordinating commissioner); or

- a letter explaining why neither of the above applies.

This letter (in place of either a signed contract or arbitration papers) should contain a short account of the key issues outstanding, the steps taken to resolve the issues and any dispute resolution processes taking place locally to conclude the position.

NHS Improvement and NHS England will review this letter and discuss the issues. Between us we will endeavour to understand the issues and consider where the balance lies between the parties in failing to resolve the dispute. Where NHS England has reason to believe that the commissioner has acted unreasonably, it will immediately consider whether any breach of duties may have occurred, which would be covered by the CCG improvement and assessment framework, possibly leading to an intervention or direction. Where NHS Improvement has reason to believe that the FT has acted unreasonably, it will immediately consider whether an investigation, possibly leading to regulatory action, is appropriate.

An FT that refuses to enter into the NHS arbitration process may also forfeit some or all of its entitlement to STF monies. Similarly if a commissioner refuses to enter

binding NHS arbitration, the commissioner may forfeit any quality premium payments due for 2017/18 and may not be eligible for any vanguard or transformation funding.

2.5 Disputes involving independent or third sector providers

Where the provider is an independent or third sector provider, the parties may by mutual agreement choose to enter the arbitration process.

2.6 Disputes which have material financial implications

The informal stages of the dispute resolution process do not carry set limits; however the cost of entering mediation should be borne in mind by parties before initiating this element of the process. The arbitration process will be available only for disputes which have material financial implications. For disputes that fall below the thresholds set, it is imperative that commissioners and providers resolve them outside of this process.

The arbitration process is applicable to each dispute item for which the total full-year value of the disputed item, in aggregate across all commissioners, is either:

- over 1% of the expected annual contract value for the contract; or
- over £1,000,000 if higher.

In terms of the presentation of issues by the parties in dispute, an issue may consist of a number of matters grouped together due to a common point of principle; however they must be demonstrably linked, not merely aggregated to lift the issue over the dispute threshold.

Where disputes fall below this materiality threshold, it is essential that the parties resolve these themselves at local level. This process will only apply to lower-value disputes if the circumstances are exceptional, as determined by NHS England and NHS Improvement.

2.7 What is a signed contract?

For the avoidance of doubt, completion of Heads of Agreement or Heads of Terms, or equivalent documentation, does not constitute satisfactory agreement. On 9 January 2017, all parties will be required to evidence agreement by providing a scanned copy of the signature page, together with a list of any minor non-material unresolved items which the parties accept can be finalised after contract signature.

Satisfactory agreement of contracts constitutes:

- signature of the contract by the co-ordinating commissioner and the provider;

- confirmation by the co-ordinating commissioner that other commissioners party to the contract are content with the outcome of negotiations; and

- inclusion within the signed contract of all key schedules, including Indicative Activity Plan (2B), Local Prices (3A), Marginal Rate Emergency Rule (3D), Emergency Re-admissions Threshold (3E), Expected Annual Contract Value (3F),

Local Quality Requirements (4C), and Reporting Requirements (6B). The CQUIN schedule (4E) should be agreed in full by 23 December 2016.

3 Outline of the dispute resolution process

This dispute resolution process operates in two stages, consistent with the revised national timetable.

The first stage involves **advice and/or mediation**, which must be undertaken locally. CCG commissioners and providers should notify NHS England and NHS Improvement by 5 December that they wish to enter mediation. NHS England and the NHS Improvement will agree with the parties if mediation will be undertaken via Regional teams or through an external mediator. Mediation required for direct commissioning and for cases involving FTs will always be undertaken by an external mediator. The mediation stage is described in section 4, which also details other ways in which NHS England and NHS Improvement can assist the parties in resolving disagreements at an early point.

The second stage involves last-resort **formal arbitration**, which will be organised by NHS England and NHS Improvement. This is described in section 5. In each case, an Arbitration Panel will be established. To ensure no conflict of interest from the mediation stage, the panel for disputes involving CCGs and NHS trusts will consist of senior staff within NHS England and NHS Improvement from different Regional teams to those that undertook any mediation. In other cases, including all disputes involving NHS England direct commissioning and FTs, an independent third-party panel will be established.

Details on how the different stages of the process are triggered are set out in sections 4 and 5.

The overall timeline for the process will be as follows:

Milestone	Description	Date
Milestone 1	Local decision whether or not to enter mediation, and communication of this: • to NHS England and NHS Improvement; • to boards / governing bodies as appropriate, as per section 4.	By close of business on 5 December 2016
Milestone 2	National deadline for signing of contracts	23 December 2016
Milestone 3	Parties to present themselves to the Chief Executives of NHS Improvement and NHS England (or their representatives).	3-6 January 2017
Milestone 4	Submission of appropriate documentation (see sections 2.3 and 2.4)	9 January 2017

Milestone	Description	Date
Milestone 5	Arbitration Panel and/or hearing.	10-25 January 2017
Milestone 6	Written arbitration findings issued to both parties.	By 2 working days after panel date
Milestone 7	Contract and schedule revisions reflecting arbitration findings completed and signed by both parties.	By 31 January 2017

It is essential that commissioners and NHS providers inform their boards or governing bodies (or the Executive Team in the case of NHS England direct commissioning contracts) when they are entering the mediation stage of the dispute resolution process. They must report clearly to boards/governing bodies, setting out the issues in dispute and the total potential charge that may be levied (see section 5) if mediation is unsuccessful and the formal arbitration process is triggered (or expected for FTs). We anticipate the boards and governing bodies will wish to ensure that every possible step has been taken to ensure timely contract signature.

4 Advice and mediation

4.1 Overview

NHS England and NHS Improvement arbitration process exists as a last resort; it is not intended to be heavily used. Commissioners and providers should make every effort locally to reach agreement on their contracts for 2017/18. To help, NHS England and NHS Improvement offer two services to parties which may be used in any combination:

- Advice on technical or other aspects of disputes – this expertise will be the same as that which is called on during arbitration, so where disputes relate to technical aspects of the contract it is strongly encouraged that this support is utilised; and
- Providing or arranging mediation.

4.2 Advice

Where there is a risk of dispute, the parties may seek advice from NHS England and NHS Improvement, either individually or jointly. NHS England and NHS Improvement can help clarify the issues, interpret guidance, share knowledge of how other parties have resolved similar disputes, and in appropriate cases make suggestions about the management of the negotiation process.

Advice on technical issues is available as follows:

- on the 2017/18-2018/19 NHS Standard Contract and CQUIN through the Contract Technical Guidance and CQUIN guidance, available at NHS Standard Contract / CQUIN;
- through the email helpdesk nhscb.contractshelp@nhs.net and also e.cquin@nhs.net; and

- on the National Tariff Payment System for 2017/18-2018/19 through the guidance available at the email helpdesk pricing@monitor.gov.uk.

NHS England and NHS Improvement, however, will not make decisions on behalf of the disputing parties when offering advice. When it appears that mediation rather than advice is required, NHS England and NHS Improvement will consult with the parties and consider offering mediation themselves - or they may offer to arrange the services of a third party, as described in the next section.

CCGs and NHS trusts are urged to discuss potential disputes with their NHS England financial assurance manager or NHS Improvement finance lead respectively, in advance of the process. They will be able to provide advice on technical issues and assist organisations in achieving resolution by ensuring there is a thorough and joint understanding of their positions.

Direct commissioning teams should discuss any potential disputes with the NHS England Regional Directors of Finance and Commissioning.

For the 2017/18 – 2018/19 contracting round NHS England and NHS Improvement will work with NHS Providers and NHS Clinical Commissioners to establish a standing group including NHS England and NHS Improvement representatives to help resolve issues in real time and so avoid arbitration.

4.3 Arrangement of mediation

Where, even after escalation to chief executive/chief officer/area director level, the parties in dispute are not confident that 2017/18 contracts will be agreed by 23 December 2016, they should initiate a process of mediation. In the case of disputes involving NHS FTs and independent providers, it is for the parties to consider whether external mediation is appropriate.

Local decisions on whether mediation is required should be made by no later than 5 December 2016. After agreeing the status of the contract with the provider, the Co-ordinating commissioner must email NHS England and NHS Improvement, using the contact details set out in Appendix 4, and copying the provider, to confirm whether the parties are:

- entering local mediation, and therefore wish to agree if this will be offered by NHS England/NHS Improvement or if an external mediator will be appointed (all FT cases); or
- confident of signing their contract by the national deadline and therefore not entering mediation.

Again, for the avoidance of doubt, completion of Heads of Agreement or Heads of Terms, or equivalent documentation, does not constitute satisfactory agreement. On 9 January 2017 all parties will be required to evidence agreement by providing a scanned copy of the signature page, together with a list of minor non-material unresolved items which the parties accept can be finalised after contract signature. The agreed mediators will require briefing as to the nature of the issues on which the parties have been unable to agree. At the stage of entering mediation, therefore, the

parties must complete Appendices 1 and 2 of the dispute resolution process on a provisional basis and provide these to the mediator. This paperwork will facilitate a common understanding of the outstanding issues, support the mediation process and therefore avoid arbitration.

To assist the mediator Appendix 1 must be a joint statement from the two parties, with Appendix 2 being completed jointly with each party setting out the justification for the position it has taken on each disputed issue. All paperwork must be shared between the parties to ensure transparency of opinion on the disputed items. Any paperwork submitted that has not been completed on the terms outlined above will be returned to the parties for revision/correction.

4.4 Principles of mediation

The core principle of mediation is that the mediator does not impose solutions; rather, ownership for solutions remains with the parties themselves.

Mediators can have impact at three levels. They can:

- restructure the process – the mediator may push for changes to the negotiating process. For example, the mediator may attempt to de-couple issues, pushing the parties to 'bank' what can be settled rather than adopting a 'nothing is agreed until everything is agreed' attitude;
- facilitate the discussion – as well as redesigning the process, the mediator may also join the conversation. For example, a mediator can calm tensions by recommending speakers rephrase statements; and
- engage on the content – the mediator can go further than restructuring the process and guiding the discussion: they can engage on issues of content. For example, the mediator can propose (non-technical) solutions that draw on elements of each party's offer or generate a creative solution by looking at the issue in a new way.

4.5 Executive review pre- arbitration

Where the support offered through the mediation and advice stage of dispute resolution has not led to an agreement of contracts, an intermediary step before arbitration will be introduced for 2017/18 – 2018/19 contracts. Provider and commissioner chief executives will be required to meet with NHS England and NHS Improvement Chief Executives, or their nominees, to summarise:

- The steps that have been taken so far in the contracting round to reach agreement in relation to the outstanding contract/s;
- Explanation of the area of dispute and outstanding items which have prevented contractual agreement; and
- A clearly agreed series of next steps to resolve outstanding items and achieve contract signature.

The value of this step is the added assurance that all available options to settle contracts have sufficiently been tried and exhausted with the intention that this clarity will reduce the number of cases that enter formal arbitration.

5 Arbitration

5.1 Overview

It is hoped that following a process of local negotiations, advice and mediation, all contracts should be signed by the national deadline.

However, where a satisfactory agreement of contracts (refer section 2.7) has not been achieved by 23 December 2016, the parties will be expected to enter arbitration.

Entering the arbitration process will require the parties to submit joint documentation concerning the dispute to NHS England and NHS Improvement by noon on 9 January 2017.

Prior to submission of the paperwork both the commissioner and provider must ensure that the paperwork correctly reflects the position of both parties. Draft paperwork must be shared properly between the parties prior to submission to present a consistent case. Failure to do so will result in the paperwork being returned to the parties for revision/correction. Where contracts have not been agreed by 23 December, parties are advised to begin drafting arbitration papers straight away, to allow for timely joint submission.

5.2 The Arbitration Panel

An Arbitration Panel will be established for each dispute.

Where the dispute is between a CCG and an NHS trust, NHS England and NHS Improvement will jointly review the submissions and determine the most appropriate method of arbitration. Where no conflict of interest exists, they may decide to establish an internal arbitration panel, consisting of senior staff from the two organisations, or otherwise to refer the issue to an independent, third party arbitration panel.

Should the dispute involve either a direct commissioner or an FT, the panel convened to consider the arbitration will be completely independent of the rest of the NHS and so completely unbiased. The charge for entering the arbitration process for 2017/18 and 2018/19 will be at an equivalent cost to external dispute panels.

Terms of Reference will be in place for the independent panels, and within the scope of this will be a clear requirement of the panel members to disclose any conflict/connection with organisations in arbitration. As noted above, the panel will be independent of the rest of the NHS but the membership will have had experience of the NHS at executive director or non-executive director level. As a result, it is important that any conflicts are declared so that they can be excluded from any cases where impartiality is at risk so that the integrity of the process is maintained. As in previous years a register of interests will be maintained for all panel members.

The panel will be jointly commissioned by NHS England and NHS Improvement, and both organisations will be required to support the appointment of panel members. Depending on the volume of direct commissioning disputes, the same panel may be used for all related disputes.

Arbitration panels are able to call on national expert advice at their discretion. For example, the standard contract team can provide advice on contracting issues arising from the NHS standard contract.

5.3 Method of arbitration

Arbitration will be conducted using the 'pendulum principle' for each issue (also known as 'final-offer' adjudication). This means that the arbitration panel can only find wholly in favour of the commissioner or the provider; they cannot propose a different solution or split the difference. If two parties have multiple areas of dispute, these will be considered separately.

5.4 Rationale for the pendulum principle

Application of the pendulum principle is designed to reduce the need for arbitration in the first place. The party whose proposal will be accepted will be the one whose stance is consistent with guidance or, in matters where guidance does not determine the adjudication, is closest to what the arbitration panel believes is reasonable.

The panel will apply the pendulum principle to the most recent proposal made by each side. To ensure that each party is aware of the other's offer, it must form part of the joint understanding of the disputed value.

5.5 Application of the pendulum principle

Where there are multiple areas of dispute between parties, these will normally be treated separately by the arbitration panel and the pendulum principle applied to each issue. However, the panel may at its discretion decide to adjudicate once across a number of issues it perceives to be linked.

5.6 Factors the Arbitration Panel will consider

In deciding the case, the arbitration panel will consider the relative reasonableness of the two final-offer proposals. In so doing, they will act in accordance with the overarching principles attached at Appendix 3, which include principles established as a result of previous arbitrations.

The Panel cannot consider the financial position of the two organisations. The role of arbitration is not to manage health economy-wide financial balance.

Commissioners, NHS trusts and FTs will be required to submit the contract tracker throughout the planning process (see 2017/18-2018/19 operational planning and contracting guidance). Where a party does not consistently make the required submission and subsequently enters arbitration, this may be counted against that party by the panel in reaching its decision.

In exceptional circumstances, as determined by the panel, the behaviour of the parties may be taken into account in their final decision.

5.7 Charges for entering arbitration

A charge will be levied on parties who enter arbitration. The amount levied will be used to fund the arbitration panels.

The charge for entering arbitration will be decided upon by NHS England and NHS Improvement and notified to the parties in advance of the arbitration panel. The charge will either be split equally between the parties or in such other way as the panel may decide.

5.8 Information to be provided to the Arbitration Panel

The Arbitration Panel will require submission of the joint papers detailed below. The joint papers must not be accompanied by further supporting information or embedded documents. Any supplementary information will not be considered by the panel. This is to reduce the burden on the panel and to put the nature of the dispute into sharper relief. The parties must submit papers as follows:

- Questionnaire response
  This is designed to ensure that the panel has the necessary core information. The questionnaire can be found within Appendix 1 of this guidance. It requests factual information, including a brief description of each issue and its value. It should not be used to set out each party's argument - this should be detailed in Appendix 2.This must be agreed between the parties and then submitted by the co-ordinating commissioner to NHS England and NHS Improvement (and copied to the provider).

- Summary of disputed issues
  This should be completed in the format shown at Appendix 2 of this guidance. Appendix 2 must be agreed by both parties before submission. Each party must submit a completed copy of Appendix 2 to NHS England and NHS Improvement, copying in the other party.

All documents must be submitted by noon on 9 January 2017 in line with the detailed requirements set out in Appendix 4.

Once it has reviewed the Appendices 1 and 2, the arbitration panel may request further information from either party. The parties must respond promptly and provide a reasonable level of detail that summarises their position; the panel will not consider overly long responses. Each organisation must copy their response to the other party.

After the arbitration panel has considered these documents, it may choose to meet with both the parties together. If it does, the delegation from each party must include the chief executive/chief officer/area director. At this session, each party may present for a maximum of 15 minutes. The adjudicators will then ask questions to the parties, for a maximum of 30 minutes. No more than three delegates from each party may attend the panel hearing.

5.9 Communication of the Arbitration Panel decision

Once the Arbitration Panel has reached its decision, it will write jointly to both parties, two working days after the panel date, informing them of the outcome of the arbitration. This letter will confirm how each of the disputed issues is to be handled so that the parties can agree a contract value for 2017/18 - 2018/19.

Within 24 hours of receipt of the outcome letter, the parties to the arbitration will have the option to hold a clarification phone call with the panel chair. This call will be for the purpose of factual clarification of the outcome (rather than to discuss the justification for the panel's decision) and to ensure that no ambiguity or difference in interpretation follows. The call will be recorded and minuted verbatim.

Organisations must implement the decisions immediately and reflect the outcome in 2017/18 – 2018/19 contracts, which must be signed on or before 31 January 2017. The decisions of the arbitration panel will be final, binding on both parties and not subject to appeal.

Each organisation must report the outcome of the arbitration process to its board or governing body.

Questionnaire for parties entering arbitration

These notes are intended as a guide for completion of the template, which must fill no more than two sides of A4 when submitted.

1. Name of commissioner	**2. Name of provider**
3. Key contact at commissioner (name and full contact details)	**4. Key contact at provider (name and full contact details)**
This should be the person to whom all queries and requests for further information should be addressed	*This should be the person to whom all queries and requests for further information should be addressed*

5. What are the issues under dispute?

List all of the disputed issues briefly and factually, giving the value of each

Issue 1 Description

Commissioner Proposal	£X
Issue under dispute	£X
Difference	£X

6. What is the total value of the dispute?

Complete the table below; the difference should equate to the sum of the disputed issues.

Commissioner proposed contract value	£X
Provider proposed contract value	£X
Difference	£X

7. How have you attempted to resolve this dispute and why have you been unable to?

Must demonstrate that negotiations have been escalated to chief executive / chief officer level and that an external mediation process has taken place

8. Is there anything else the panel needs to know to make an informed decision?

9. Signature of Chief Executives

Name of Chief Executive **Email:** **Date:**	**Name of Chief Executive** **Email:** **Date:**

Summary of disputed issues

Area	
Issue 1 – heading *Please complete a new sheet for each dispute.* *The summary for each dispute should not be more than 2 sides of A4 and must not include any embedded documents.*	
Issue	
Provide brief description of issue under dispute	
Value of each issue under dispute	
Agreed difference in value for each issue (£s)	
Guidance	
Please specify any relevant guidance that you have used in making your cases	
View from XX Trust	**View from XX Commissioner/XX**
Please provide a concise description of the dispute	*Please provide a concise description of the dispute*

Joint Contract Dispute Resolution Principles

The parties should have regard to the following national guidance when agreeing contracts:

- 2017/18 – 2018/19 NHS Standard Contract and Contract Technical Guidance;
- 2017/18 – 2018/19 National Tariff guidance;
- 2017/18 – 2018/19 CQUIN guidance, and
- Dispute Resolution Process for the 2017/18 – 2018/19 Contracting Process.

Where there is no national guidance relevant to a specific issue, the parties should apply the following principles:

- **Local agreements must be in the best interests of patients** - They must maintain the quality of health care now and in the future, support innovation where appropriate, make care more cost effective and allocate risk effectively.
- **Local agreements must promote transparency and accountability** - They should make commissioners and providers accountable to each other and to patients, and facilitate the sharing of best practice.
- **Providers and commissioners must engage constructively with each other when trying to reach local agreements** - This should involve agreeing a framework for negotiations, sharing relevant information, engaging clinicians and other stakeholders where appropriate, and agreeing appropriate joint objectives for service Improvement and delivery.
- **The financial position of the two organisations should not be considered in the resolution of disputes** - A rules based approach will be adopted.

Area for consideration	Specific issues	Approach to be taken in dispute resolution
NHS Standard Contract	Deviations from standard national contract	All commissioners and providers must use the NHS Standard Contract 2017/18 – 2018/19, in line with the detailed provisions set out in the contract technical guidance. Where a multi-year contract is in place, the parties must apply the published national variation to update their contract for 2017/18 – 2018/19. Mandated national text of the contract or the national variation must not be varied locally. Where both parties are in agreement local clauses such as sanctions / KPIs may be included in the contract but if agreement cannot be reached then the default position is that no local arrangements will be included.
CQUIN	Deviations from national CQUIN schemes and guidance	To the extent that CQUIN guidance allows for local flexibility for CQUIN variation (that is, local agreement between commissioner and provider to vary the normal application of the national CQUIN scheme and guidance) such variations can only be put in place if both parties are in agreement. If agreement cannot be reached, then the default position is that no CQUIN variation will be applied.

Area for consideration	Specific issues	Approach to be taken in dispute resolution
Negotiation of local prices where the services are not subject to national prices in the National Tariff	Negotiation of unit prices for locally priced services	Where both parties agree that local prices (i.e. prices for services not subject to national prices in the National Tariff) need revision, the expectation is that a jointly agreed and fully transparent review can be carried out to understand how this can be achieved – for example moving to a reasonable benchmark price is acceptable, as is using benchmarking data to flag which prices may need review. However, parties must demonstrate that they have addressed any issues of 'cherry picking' by either party. Pace of change in moving to benchmark price can be considered in the context of the scale of change, and within the guidance provided in the national tariff. Efficiency savings schemes that relate solely to price changes will not be accepted unless they are a renegotiation of unit prices for services outside of the tariff and the above guidance is followed.

Area for consideration	Specific issues	Approach to be taken in dispute resolution
Activity Plan setting	Demand / capacity Planning	Commissioners should determine demand requirements to inform activity plans. The start point for this is the baseline forecast outturn produced for providers and commissioners. This has been based on activity over the 12 month period up to month 3 2016/17 plus historical growth. Commissioners should consider health needs and demographic change for the upcoming year: • any planned changes in patient flows, • adjusted for full year effects of recurring changes that started after 1 April 2016 and any non-recurring activity changes, • considered the need to maintain elective referral to treatment times, • the application of changes in commissioning policy that impact on the volume of care commissioned, • Efficiency savings/ BCF schemes that would affect patient volumes or pathway steps needed to treat patients. Whilst it is for commissioners to determine their total purchasing across contracted providers, constructive engagement will be evidenced by giving due consideration where providers have provided additional intelligence about future demand. When agreeing contracts, providers must be cognisant of the level of capacity that they have in order to meet demand in a safe and sustainable way. Unless agreed by both parties, commissioners should not cap activity based payments or otherwise distort a provider's incentives to attract additional patients. When agreeing contracts, providers must be cognisant of the level of capacity that they have in order to meet demand in a safe and sustainable way.

Area for consideration	Specific issues	Approach to be taken in dispute resolution
Activity Plan setting	2017/18 activity plan changes from changes in commissioning policy	Unless agreed by both parties, commissioners should not cap activity based payments or otherwise distort a providers incentives to attract additional patients. It is accepted that commissioners have the right to commission changes to clinical pathways and agree contracts on that basis. Commissioners' policies and service specifications should be informed by considering available evidence and where appropriate, by clinical, patient and public engagement.
Activity Plan setting	2017/18 volume changes from commissioner Efficiency Savings / BCF schemes	Efficiency savings/BCF impacts on activity plans will need to have a clear rationale for the scale and timing of impact, be underpinned by robust plans that are properly formed, have clinical engagement, contain measurable objectives, measurable success criteria and a trajectory for delivery of efficiency savings / BCF plans. Efficiency savings/BCF schemes should also include details of: • Revised volumes of care to be delivered, at a granular level of detail; • Assumptions that have been tested and includes realistic trajectories and profiles; and • KPIs that have been developed to measure the success of the efficiency savings/BCF scheme to enable each party to understand if the scheme is
Sanctions	Reductions to Baselines for impact of financial sanctions	Financial sanctions are non-recurring. No impact of financial sanctions should be built into expected the contract values for 2017/18 – 2018/19.

Area for consideration	Specific issues	Approach to be taken in dispute resolution
Emergency Threshold Rebasing	Application of guidance in the National Tariff	National Tariff guidance covers the marginal rate emergency rule. This sets out that baseline values must therefore be set according to 2008/09 activity levels, but giving flexibility for adjustments where there have been material changes to the pattern of emergency care in a local health economy commissioners and providers must consider whether the evidence base is robust and in line with the National Tariff guidance provided for appropriate baseline changes.
Commissioner responsibility	Uncertainty as to which commissioner is responsible for commissioning services that may be affected by co-commissioning	Where there is a lack of agreement between commissioners, the applicable 'identification rules' in force as at the point of contract signature will determine whether activity is reflected in specialised contracts or CCG contracts. Any changes moving responsibility between commissioners during 2017/18 – 2018/19 will be actioned as an in-year variation.
Reporting Requirements		Reporting requirement and any Data Quality Improvement Plans in contracts should be agreed in line with the NHS Standard Contract and Contract Technical Guidance.

The contact e-mail addresses for mediation and arbitration papers are set out below. Please refer to the main body of the guidance for process and timetable details and Appendices 1 and 2 for standard templates that must be submitted for each mediation and arbitration case.

NHS England contact details:

NHS England Region	Mediation and arbitration papers email address for submission
North	england.planning-north@nhs.net
Midlands and East	philipmorris@nhs.net
London	england.londonsubmissions@nhs.net
South	ENGLAND.Financesouth@nhs.net

NHS Improvement contact details:

Location of Trust	Email address
North of England	NHSI.planningnorth@nhs.net
Midlands and East	NHSI.planningmande@nhs.net
London	NHSI.planninglondon@nhs.net
South of England	NHSI.planningsouth@nhs.net